

**BREWTON-PARKER COLLEGE
HEALTH/MEDICAL QUESTIONNAIRE**

HEALTH HISTORY

Student Name: _____
(PLEASE PRINT CLEARLY)

SSN: ____/____/____ Sex: ____ F ____ M

Date of Birth: ____/____/____ Weight: ____ Height: ____

This form must be completed and returned prior to moving into the residence hall. Please return form to:

Department of Residence Life
Brewton-Parker College
P.O. Box 197
Mt. Vernon, GA 30445

EMERGENCY CONTACT INFORMATION

Name: _____

Address: _____

City, State and ZIP: _____

Home Telephone: _____

Work Telephone: _____

Relationship to Student (Parent or Legal Guardian): _____

Have you ever or are you currently being treated for the following:

- | | |
|--|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Frequent or Severe Headaches | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Fainting Spells or Dizziness | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Epilepsy or Convulsions | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Ear, Nose, or Throat Problems | <input type="checkbox"/> Depression/Mental Illness |
| <input type="checkbox"/> Blood Disorder (e.g. Anemia) | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Drug or Alcohol Problems | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Handicap (Explain) | |

Please list any and all medications you are currently taking (including Rx medications, over the counter medication, and herbal medicine):

History of major illnesses or injury (attach extra sheet if needed):

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

In case of serious illness or accident, I give Brewton-Parker College or its representative(s) permission to secure medical care, which may include transportation to a doctor or hospital. I understand that I am financially responsible for any and all expenses incurred.

I have read, understand, and agree with the above statement.

Student: _____ Date: _____

Parent/Guardian: _____ Date: _____

<p>TO BE COMPLETED BY STUDENT AFFAIRS OFFICE: Insurance Company: _____ Policy Holder: _____ Policy Number: _____ Insurance Company Phone Number: _____</p>

PHYSICAL EXAM

A PHYSICIAN MUST COMPLETE THIS PORTION:

Treating Physician: _____
(PLEASE PRINT CLEARLY)

Physician's Telephone Number: _____

Physician's Office Address: _____

Blood Pressure: _____ Pulse: _____

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose Throat		
Lymph Nodes		
Heart		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Date of the following immunizations:

MMR1: _____ MMR2: _____

TB Skin Test (most recent): _____

Documentation of Disease: _____

Laboratory Titers: _____

Tetanus Shot (most recent): _____ Hepatitis A/B (optional): _____

Meningococcal Vaccine (optional but encouraged for all freshmen): _____

- Cleared: I recommend student to participate in intramural and intercollegiate sports.
- Not Cleared: I do not recommend student to participate in intramural and intercollegiate sports.
- Cleared after completing evaluation / rehabilitation for:

Comments:

Physician's Signature: _____ Date: _____

It is imperative that any important history concerning the patient's health be included, and if necessary, attached. If the student is under 18, the parent or legal guardian for the student must sign the Authorization for Treatment and Release section of this form in order for the student to receive treatment from area hospitals or doctors. *All information is confidential.*